



Sandpoint Women's Health

Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____
First Name Middle Last

Social Security #: _____ Religion: _____ Single Married Widowed Divorced

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

At what number can we leave a message? () _____

Employer: _____ Occupation: _____ Work Phone: () _____

Person to contact in emergency: _____ Phone: () _____

Family Doctor: _____ Who referred you to us? _____

Spouse / responsible party if other than patient: _____
First Name Middle Last

Social Security #: _____ D.O.B.: _____ Relationship to Patient: _____

Address: _____ Home Phone: () _____

City/State: _____ Zip: _____ Occupation: _____

INSURANCE INFORMATION (Primary) PLEASE PROVIDE INSURANCE CARD FOR US TO COPY

Insurance Co.: _____ Address: _____

City/State: _____ Zip: _____ Insurance Co. Phone: () _____

Policy Holder: _____ Date of Birth: _____

ID / Policy #: _____ Group #: _____

INSURANCE INFORMATION (Secondary) PLEASE PROVIDE INSURANCE CARD FOR US TO COPY

Insurance Co.: _____ Address: _____

City/State: _____ Zip: _____ Insurance Co. Phone: () _____

Policy Holder: _____ Date of Birth: _____

ID / Policy #: _____ Group #: _____

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me and that I am willing to make specific arrangements to pay whatever part that is not covered by insurance on a timely basis. (PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT). IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICES VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I grant permission to my physician to mutually exchange medical information with my referring physician(s) and/or their associates. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record to my insurance carrier and Medigap carrier. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection, I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT / SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made directly to SANDPOINT WOMEN'S HEALTH, P.A., for any service provided me by SANDPOINT WOMEN'S HEALTH, P.A., providers. I authorize SANDPOINT WOMEN'S HEALTH providers to release information to HCFA and its agents any information needed to determine benefits.

PATIENT SIGNATURE: _____ DATE: _____